Donna Sigl-Davies, MA, PCC-S
6797 N. High Street., Suite 244, Worthington, OH, 43085 | Ph: 614.505.7561 | Fax: 614.505.7562
www.tapesterycounseling associates.com

GOOD FAITH ESTIMATE

for Use of Out-of-Network Insurance or Private Pay

Under Section 2799B-6 of the Public Health Service Act, health care providers and health care facilities are required to inform individuals who are not enrolled in a plan or coverage or a Federal health care program, or not seeking to file a claim with their plan or coverage both orally and in writing of their ability, upon request or at the time of scheduling health care items and services, to receive a “Good Faith Estimate” of expected charges.

You have the right to receive a “Good Faith Estimate” explaining how much your medical care will cost

Under the law, health care providers need to give patients who don’t have insurance or who are not using insurance an estimate of the bill for medical items and services.

You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.

Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.

If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.

Make sure to save a copy or picture of your Good Faith Estimate. For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises.

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created. The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur.

Ohio Law/ Consent to Treat:

The Ohio Counseling, Social Work and Marriage and Family Board requires all therapists to provide clients, in writing, the costs of services in a written treatment consent form prior to receiving services. This consent form outlines all costs associated with psychotherapy (CPT: 90791, 90832, 90834, 90837). Rates are the same for various locations of service: office or telehealth appointments (POS 02; POS10)

Most clients should expect to pay $145 per 45-60 minute session. Payment is required at the time of service. Clients who do not have insurance benefits or opt out of using benefits that provide insufficient coverage and are unable to afford services at the full fee may qualify for hardship waiver to reduce rates.

Most clients attend one to four psychotherapy sessions per month. Most frequently psychotherapy sessions, occur twice per month and decrease with progress towards goals. Ultimately, as the client, it is your decision when to stop therapy.
As a strength-based and client-centered practice, we empower our clients to determine their own course of mental health treatment (including but not limited to: frequency of treatment, choice of clinician, length of service). It is not possible to know in advance how many sessions a person may need.

Insured Clients:
Donna is out-of-network with all insurance companies, except Medical Mutual of Ohio. Insured clients may use out-of-network benefits and Donna will file the claims with your policy. The out-of-pocket cost of therapy will depend entirely on your specific insurance plan. Donna is not qualified to interpret your insurance benefits and recommends you contact your insurance company to verify your specific insurance benefits.

To assist clients in obtaining the most accurate information on expected out-of-pocket costs for services when using out-of-network benefits, I recommend asking the following questions of your insurance company:

- Is psychotherapy/ outpatient mental health care covered under my plan?
- Is telehealth covered at the same rate (if applicable)?
- What is my deductible that will need to be met before I receive policy benefits?
- What portion of my therapist's bill will be applied to my deductible?
- Once I have met my deductible, what is my co-insurance or co-pay for outpatient mental health sessions?

Hardship Fee Waivers:
In order to increase access of services to those in need, clients who do not have insurance, are on Medicare or Medicaid or have insufficient out-of-network benefits and choose to waive their use, may be eligible for some portion of fees to be waived based on financial eligibility. If a partial fee waiver, still does not meet the client's needs, a referral to an Medicaid/Medicare or in-network provider can be made at any time. If you might qualify for income based reduced rates, please ask for more information.

Dispute Resolution:
You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available. You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill. There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount. For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call HHS (800) 368-1019.

Donna Sigl-Davies, MA, LPCC-S 03/25/2024

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NPI: 1265507446